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SURGICAL SHOCK

By J. Fred Lessel, M.R.C.S., L.R.C.P.,
Anaesthetist, Victoria General Hospital, Halifax, N.S.

When a patient is found, after a severe injury or operation, to be in a state of depressed vitality with a cold skin, low temperature, rapid pulse of low blood-pressure, he is usually said to be in a state of shock. This condition is very common, but the series of changes in the circulation leading to it do not seem to have been fully followed and investigated during the course of the injury. From repeated observations on the facial artery during operation I have noted the following reactions, which have considerable importance in the diagnosis and treatment of shock.

(1) When sufficient irritation is applied to an area of the body, a decided contraction of all arterial muscle takes place.

(2) This contraction is sustained while the irritation is sustained, and if sufficiently severe the pulse will be obliterated. If the irritation is sufficiently severe and prolonged the obliteration of the pulse will be permanent, and immediate death result.

(3) After removal of the stimulus the artery dilates partially, but incompletely, and does not regain its normal size for some time (Fig.).

(4) With the initial irritation the pulse-rate does not rise, in some cases it may fall, but as soon as the irritation is removed, and the artery begins to dilate, the pulse-rate rises rapidly.

(5) Blood-pressure probably rises with the initial contraction, but falls rapidly with the secondary dilation.

(6) Certain regions are especially susceptible to irritation, namely, the anterior parietal peritoneum and sub-peritoneal tissues in the lateral abdominal regions. Traction applied to any solid or hollow abdominal viscus will produce similar changes in the blood-pressure.

(7) Certain regions are relatively immune, namely, the groin, the brain, the sac of a hernia, the axilla, and the central line of the abdomen below umbilicus.

(8) The alternate application of irritation and its removal results in a small, hard, contracted artery, with a low blood-pressure—the kind of pulse usually found after major operations, and usually termed the pulse of shock.

(9) These changes take place quite as regularly when the patient is under the influence of chloroform or ether as when fully conscious.

(10) The small hard pulse of low tension may be caused by mental impressions only, such as fear, pain, grief, worry, etc.

Shock then is a true reflex, and will be modified in a like manner. It may be brought about in three ways:

(i) Peripheral irritation carried by a direct path below the cortex to the vaso-motor centre. This may be termed peripheral shock.

(ii) Peripheral irritation carried to the cortical centres for the appreciation of pain and injury, and from these centres to the vaso-motor centre. This may be termed periphero-central or indirect central shock.

(iii) Impulses arising directly in the central nervous system, such as fear, worry, apprehension. This is direct central shock.

I. Cases Illustrative of Peripheral Shock of Different Grades of Severity

Case 1.—Operation: appendicectomy, no preliminary medication, deep ether anaesthesia, no reaction to skin, fascia or muscular division. The operator then elected to tear down on the peritoneum. Immediately there was a reaction—respiratory movements increased in depth, face became pale, veins of neck, chest, and arms engorged, facial artery contracted, became hard, and lost some of its tortuous curves, showing shortening. The irritation was only of a few seconds duration, and when removed the artery dilated to nearly normal, became soft, the face resumed color, the veins subsided, and the pulse-rate rose from about 70 to 100.

This illustrates moderately severe transitory shock.

Case 2.—Intestinal obstruction. At the completion of the operation large masses of intestinal coils, which had been removed from the abdomen and which had been lying quietly protected by wet towels, were quickly swept into the abdomen. The facial artery contracted to a hard pulseless cord in four or five beats, remained so for twenty seconds, then resumed pulsation through a hard contracted artery to one of more rapid rate and of increasing softness and elasticity.

This illustrates severe transitory shock; no doubt if prolonged it would have caused immediate death.

Case 3.—Perforated duodenal ulcer thirty hours previously; general peritonitis. Pulse hard, wiry, contracted, rate 120. No alteration of character or rate under anaesthesia (ether). On opening the abdomen, intestines bulged sharply into the incision, due to enormous gas pressure in the bowel. Pulse became still more hard and small, and in three or four pulsations ceased to beat. A few spasmodic respiratory movements were made and all life ceased.

This illustrates very severe shock sustained and added to pre-existing shock which had not been abolished by inhalation anaesthesia.

Just here it might be well to note that the pulse usually described as the pulse of peritonitis—hard, wiry, "running" in character—is in reality the pulse of severe nervous irritation or the pulse of shock, whether that irritation be chemical, bacterial, toxic, or mechanical, in or out of the abdomen.

II. Indirect Central Shock

Case 4.—Italian laborer unable to speak English. Severe lacerated injury to the leg received in a railway accident about twenty-four hours previous to admission to hospital. He was very much perturbed mentally and no doubt in much pain. Pulse rate 110, quite hard and contracted, but when placed under the influence of ether, pulse fell to 70 and became full and bounding. Amputation performed, and pulse did not subsequently rise above 80.

This illustrates shock due to mental impression combined with pain passing to the cortex and thence to the vaso-motor centre. When the cortex was cut off by the anaesthetic, shock vanished.

Numerous similar cases, as burns, superficial injuries, etc., readily illustrate this variety of shock.

III. Direct Central Shock

Cases to illustrate minor degrees of this variety may be demonstrated in the wards of those about to undergo operation. The patients, usually men, will deny this fear, but acknowledge nervousness. The pulse will be found above 100, and a degree of contraction will be easily felt if one is accustomed to look for this sign. By reassurance or by means of a hypodermic of morphia and scopolamine this pulse may be made to resume a normal character.

Cases of exophthalmic goitre show this pulse frequently.

Grief, sudden bad news, has caused death. Pallor of the face, showing arterial contraction, is a well-known clinical sign. Joy, on the other hand, is characterized by a flushed face and has the reputation of never killing.

The act of vomiting is accompanied by pallor.

Excitement, as of a soldier in battle, shows peripheral dilation and immediate shock is little felt.

Death has been caused by minor operations; and the use of vaso-constrictor adrenalin on a mucous membrane seems to predispose to this event.

The statement has been made that shock is a reflex action and if reflex actions are abolished, shock is not present. This is true where concussion has preceded or accompanied injury.

Man, age 75 years, struck in the left side by a shunting engine with sufficient force to comminute all the bones of the arm into pieces about two inches in length. He was knocked down, and the wheels passed over his left foot—surely a very grave injury. On admission to ward, pulse was 40, weak, and hardly perceptible; skin cold, inelastic, and cadaverous; knee-jerk absent. In about two hours pulse rose to 80, full, and very soft. Patient next day stood amputation of both leg and arm without increase of pulse tension and without subsequent acceleration.

In this case the man complained of very little pain, and the general concussion of the whole body protected him against nerve irritation and shock—the artery showing absolutely no contraction.

Probably the most vexed question in the study of shock has been to explain a low blood-pressure with contracted arteries. Low blood-pressure could be explained on the assumption of an exhausted vaso-motor centre (Crile), but a contracted artery could not. The logical explanation seems to be that there is no exhaustion of the vaso-motor centre, that the contracted artery is contracted as regards normal size, but is really dilated relatively to the contracture which took place at the time the injury or nerve irritation was inflicted. This seems to fit all the known facts, and correlates the several schools of thought on the subject. The low blood-pressure will cause general arterial anaemia and form a vicious circle. Cardiac anaemia results in diminished cardiac contraction, and so little force is behind the blood in the aorta that it fails to overcome the contraction of the artery. This condition is usually termed collapse.

The distribution of the blood fluid in shock is of interest, and may be arrived at by a process of exclusion. It is not in the arteries, as they are contracted and blood-pressure is low. It is not in the surface veins, as these are collapsed. The fluid portion of the blood has not escaped from the vessels, as oedema is not a feature of shock; and Rendle Short has shown that the specific gravity of blood is not raised. There remain only the great veins of the splanchnic area, where, I believe, the great bulk of the vital fluid is regularly found. In cases of shock which come to post-mortem examination there is direct evidence of venous pooling.

Of the contributory factors in shock, haemorrhage is probably the most profound; viewed in the light of the preceding arterial changes the loss of even one ounce of arterial blood makes a very grave impression on the already severe arterial anaemia.

Loss of body heat is probably second in importance. Coldness of the extremities—hands, feet, and ears—are good diagnostic signs of shock during operation.

Acapnia in itself is not a direct cause of shock; in fact the great

muscular relaxation present in this condition may protect the patient to a certain extent. But on the other hand, if acapnia develops after shock is established, the double condition would be extremely fatal.

Diagnosis

Shock has always been a matter of opinion, there has been no certain sign to distinguish it from concussion, haemorrhage, acapnia, heat exhaustion, etc. But if an estimate is made of the contraction of the arterial wall, shock may be diagnosed as either alone or complicated by other sources of lowered vitality. During operation the surgeon may be warned of causing nerve irritation, and the exact seats of susceptibility mapped out and avoided. By carefully following the artery during operation and using reasonable judgment, the pulse rate of a patient four hours after may be prophesied to within ten beats.

Treatment

I shall discuss only a few of the best known and most frequently used measures and drugs, because my experience in the light of arterial constriction only covers the rather limited field of a few hundred cases.

(1) The anaesthetic. Inhalation anaesthetics, N_2O, chloroform, and ether, do not cut off peripheral shock unless carried to such a depth that blood-pressure is greatly lowered, in other words, unless fourth stage anaesthesia is established. This stage is rightly considered by most authorities to be too dangerous a degree. There are, however, occasional cases, such as Case 3, where arterial spasm must be overcome, so that we would be justified in giving a much deeper anaesthetic than would be allowable under ordinary circumstances.

Inhalation anaesthetics do, however, cut off direct and indirect central shock.

(2) Alcohol is an anaesthetic and vaso-dilator. A person so well under the influence of spirits as to be called drunk suffers very little shock from injury while in this condition.

It would be good practice, then, to administer alcohol immediately after injury where pain and arterial contraction are in evidence, but very bad practice to give alcohol where pain is absent and pressure low. Alcohol is thus contra-indicated in collapse following operation. The question to give or withhold alcohol may be answered by asking ourselves, would a light ether anaesthesia do our patient good? If yes, give spirits; if no, withhold.

(3) Strychnine increases the reaction of muscle to nervous influence. The value of strychnine in shock has been frequently discussed; it may be settled quickly. If shock is expected do not give it. If shock is present also withhold it. If shock has passed off, leaving effects which are sometimes known as collapse, strychnine may be of value.

In all cases where arterial contraction is due to over-stimulation of the vaso-motor centre, strychnine is contra-indicated.

(4) Morphia depresses all reflex actions, both on vessels and on muscles. It is of exceptional value in shock expected and in shock present, but must be used carefully. No single dose should be over ¼ gr. and the dose should not be repeated more often than every fifteen minutes. It should not be given again after its effects are manifest for about four hours.

Morphia 1-6 gr., combined with atropine 1-150 gr., or scopolamine 1-150 gr., should be given before all operations, whether under general, local, or spinal anaesthesia.

(5) Hyoscine hydrobromide or scopolamine in a dose of 1-150 gr. combined with morphia 1-6 gr. is an ideal preliminary medication dose. It dissociates the different centres from their action on the vaso-motor, prevents central shock and periphero-central shock by cutting out the memory for previous injury and putting the patient in the same class as a new-born baby with no previous impressions, the new-born being relatively free from shock.

(6) Saline infusion, subcutaneous, intra-venous, and rectal are all valuable, but the most valuable of these is rectal in massive amounts. The patient is elevated 18 in. at the feet, and saline solution at 115° F. is poured in the bowel until it will hold no more, from 40 oz. to 80 oz. or even more are used. It has three effects: (1) It exerts its direct pressure on the splanchnic venous area; (2) it introduces 5 lb. of fluid at a temperature 17° F. above that of the body; (3) it is directly absorbed. Rectal saline is quick, effective, easy to give by inexperienced assistants and with little apparatus; also it does not interfere with intra-venous or subcutaneous injections.

Intra-venous infusion has the objection that the cases that need it the most are the most difficult to treat. It is useful where intra-rectal is contra-indicated as where a colotomy has been performed or where an anastomosis of the large bowel has been made, otherwise it should be preceded by intra-rectal 40 oz. to prevent blood dilution, by exerting pressure on splanchnic veins.

Subcutaneous infusion—under the breast in women, into the axilla in men—is useful where the previous two cannot be used, but is much inferior in its effects.

(7) A drug is required in the treatment of shock that directly increases the force of the heart without much effect on the vessels. Pituitary extract seems to have a greater effect on the heart than on the vessels. It is not ideal, but with its tonic effect on the bowel the general net result is to get the blood back out of the abdominal veins into the arteries. It is certainly valuable in doses of 1 c.c. every one, two, or three hours for three doses.

(8) Camphor is also a valuable cardiac muscular stimulant and should be used in 3 gr. doses hypodermically in oil every hour for five or six doses.

(9) Nitroglycerine should have a place in the treatment of arterial spasm. It should be used in doses of 1-100 gr. hypodermically and repeated in ten minutes if its effects are not manifest. Its effects last about three-quarters of an hour.

(10) Heat to the surface is valuable in keeping up the peripheral circulation; it is of value in shock expected or present, or in collapse.

Routine Treatment

(1) Shock absent but expected. Give morphia 1-6 gr. in combination with atropine 1-150 gr., or, better, scopolamine 1-150 gr., one hour before operation.

During operation use Crile's anoci association methods by infiltrating skin and tissues with novocaine 1-400. Especially remember that while cutting the peritoneum is almost shockless, any drag on parietal or visceral peritoneum is followed by immediate and intense shock. In cases of intestinal obstruction, the bowel may without shock be easily emptied by Moynihan's tube, provided gentleness in handling the intestines is carried out. This procedure is far less dangerous, even if the tube is inserted several times, than overhauling distended loops of bowel. Time is no objection provided there is no shock.

(2) Shock present and further shock expected. Everything possible must be done to unlock the arterial spasm present. Morphia ¼ gr. every fifteen minutes until it has its physiological action established. Chloroform in this case is the best anaesthetic, and the anaesthesia must be carried so deeply that the artery wall relaxes notably. This would be a very dangerous procedure in ordinary cases, but desperate diseases require desperate remedies.

(3) Actual nerve irritation practically absent but results of irritation present, such as are found in post-operative collapse. Elevate foot of bed, rectal saline 40–80 oz. at a temperature of 112°–115° F. Pituitary extract 1 c.c. every hour for three doses. Intra-venous saline 40 oz., camphor 3 gr. in oil every hour hypodermically for five or six doses. Possibly strychnine 1-20 gr. every three hours. I have no doubt that an ideal drug will yet be found for the treatment of shock, when it is understood that a cardiac muscular stimulant is required that does not at the same time contract the arterial muscle. *The Clinical Journal.*

THE THERAPEUTIC VALUE OF SOME OF OUR PLANTS AND SHRUBS IN THE MARITIME PROVINCES

Surely there is nothing more invigorating than a brisk walk along the seashore, the lake or tiny stream, through the woods and on to the meadows beyond, and such a tramp is what will keep us well, serene and contented.

Even though tired and worn out with a long busy day, if we seek nature, get attuned to her, we get a recreative power of mind and body that we know not of. The Book of Nature is the Book of Fate.

We hope that this meagre attempt at a short outline of the medicinal plants of the Maritime Provinces may lead us to a clearer appreciation of the wonderful variety, the exquisite beauty and real value of that neglected part of our native shrubs, trees and flowers.

In beginning we may say that many of the plants mentioned are native to most of the provinces of Canada, as well as to the bordering states.

To quote from Bulletin No. 23, Department of Agriculture: "Formerly certain drug plants growing wild in Canada were collected in sufficient quantity to supply the demand for them without any care being taken to perpetuate the species by seeds or otherwise.

The inevitable result was that they became so scarce that great difficulty was experienced in obtaining them. This was true of such species as Senaca, Snake Root, Golden Seal and Ginseng. In some localities the wild plant was almost exterminated, and it became evident that to meet future demands certain drug plants must be cultivated, or cared for like other field crops.

A few of the cultivated drug plants found are:

Carraway, seed, Carum Carui; Thyme, herb, Thymus Vulgaris; Monkshood, root, Aconitum Napellus; Nightshade, leaves and root, Atropa Belladonna; Red Poppy, petals, Papaver Rheoas; Squirting Cucumber, juice, Ecballium Elaterium; Mustard, seed, Sinapis; Foxglove, leaves, Digitalis Purpurea; Hops, strobiles, Humblus Lupulus; Flax, seed, Linum Usitatissimum; Wheat, starch, Triticum Sativum; Maize, starch, Zea Mays.

Wild:

Juniper, berries (oil), Juniper Communis; Fir, balsam, Abies Balsamea; Wild Cherry, bark, Prunus Serotina; Spearmint, oil, Mentha Viridis; Dandelion, root, Taraxacum; Black Cohosh (Snake Root), root, Cimicifuga Racemosa; Golden Seal, root, Hydrastis Canadensis; Witch Hazel, bark, Hamamelis Virginia; Indian Tobacco, leaves, Lobelia Inflata; Willow, salicine from bark, Salix.

Some unofficial plant drugs found in Canada:

Clover, tops, Trifolium Pratense; Arbor Vitea (White Cedar),

twigs, Thuja Occidentalis; Blackberry, root, Rubus Villosus; Strawberry, root, Frageria; Catnip, herb, Nepeta Cataria; Sage, herb, Salvis Officinalis; Wild Marjoram, herb, Origanum Vulgare; Marigold, herb, Calendula Offincinalis; Lettuce, juice, Lactuca Verosa; Tansy, herb, Tasacetum Vulgare; Elecampane, root, Inula Helenium; Burdock, root, Lappa Officinalis; Coltsfoot, leaves, Tussilago Farfara; Life Root, plant, Senecio Jacoboea; Boneset, leaves, Eupatorium; White Helebore, root, Verbatrum Viride; Lily of the Valley, root, Convalaria Majalis; Solomon's Seal, root, Polygonatum; Prickley Ash, bark, Xanthoxylon Americanum; Goldthread, root, Coptis Trifolium; Squaw Vine, Partridge Berry, Checker Berry, plant, Mitchella Repens; Couch Grass, Dog Grass, root, Triticum Repens; Pumpkin, seed, Pepo; Blue Cohosh, root, Caulophyllum; Culver's Root, root, Leptandra Virginiana; White Oak, bark, Quercus Alba; Chestnut, leaves, Castanea Dentata; Black Haw, root bark, Viburnum Prunifolium; Wintergreen, leaves, Gaultheria; Princes' Pine, Pipsissewa, leaves, Chimaphilla; Black Birch, bark, Betula Lentata; Pleurisy, root, Asclepias Tuberosa; Canada Hemp, Dogsbane, root, Apocynum Canadense; Sweet Flag, root, Acorus Calamus; Bladderwrack, seaweed, Fusue Vesiculosus.

The time for the collection of drug plants is most important, as the composition of the plant and the exact amount of the active principle present vary at different periods of the year.

Roots of annual plants should be dug just before the flowering period.

Barks should be collected in the Spring when the sap begins to flow; flowers just after they open and before they begin to wither; fruits should be gathered when fully ripe; seeds when ripe and just before the seed vessels split open.

To quote from Thorean, he says: "Shall I not have intelligence with the earth? Am I not partly leaves and vegetable mould myself?"

DIETETICS AND INVALID COOKING, VICTORIA GENERAL HOSPITAL, HALIFAX

1. Give the five necessary constituents in a perfect food and what each does for the human body.
2. Why are the seed classifications of vegetables more nourishing than any other class, and how do we overcome a great deal of their indigestibility?
3. What are the following: Proteid, sparers, standard diet, nutritive ratio, proteid in meat and milk, chemical formula for the carbohydrates?
4. What are the factors which effect a standard diet?
5. Discuss the feeding of a child from birth until 18 years.

6. Give the general rules to follow in making out a diet for fever, gastric ulcers, obesity, diabetes, gout.
7. Classify—beverages, vegetables, fruits, ices, soups.
8. Give the basic recipes for any five of the following: Cream of tomato soup, bouillon, plain omelet, cup of coffee, baked custard, gelatine dishes.
9. Compare the different methods of cooking eggs for an invalid, telling which are the most digestible first?
10. Give a diet for two days for a patient who has been very ill and is convalescing.
11. Give the steps taken in making any butter cake and tell how we test the temperature of an oven?
12. Discuss the digestibility and food value of milk, eggs, salads, soup, rice.

Answer any two of following—4, 7, 11, 12.

HOSPITAL SOCIAL SERVICE

By Jane Grant

The early hospital was a feature of the dawn of civilization, the first evidence of humanitarianism. Its aim was curative. If people were sick it was humanity to care for them. This labor of love was first undertaken by the church, later by the philanthropist. The modern hospital is the scientific outgrowth of the early hospital. Our aim is the health and happiness of the people—we are asking the causes of sickness and premature death, and what measures can be taken to prevent them. This change of attitude has come about by the socializing influence of individuals. The medical profession has been slow to accept the changing order, but for the last ten years unmistakable evidence is shown in the larger hospitals that the social viewpoint must be considered if we wish to treat disease successfully.

Dr. Richard Cabot, of Boston, is the pioneer promoter of Hospital Social Service.

As the charity organization society seeks not only to relieve distress and need, but studies the causes of poverty, so medical service is not only the relieving and curing of disease but primarily must know causes producing sickness, and by the prevention of disease act as a mainspring in the war against poverty and the need for almsgiving.

You ask what is Hospital Social Service? Some may tell you it is making patients happy during their sojourn in the hospital by relieving home worries; others may think it is taking patients to trains or seeing that children are receiving necessary care; some may regard

it as a reference desk to get in touch with outside agencies, but these common humanities which enter as by-play into the day of the social worker could never be an excuse for the forming of a new department in hospital regime.

The need for a social worker in connection with a hospital is only felt by individuals interested in uplift work for humanity. The need is not felt by the physician looking merely for material to teach students or the surgeon who counts the number of operations performed during the year, to thus perfect his technique. The physician and surgeon with a social conscience will be glad of the co-operation of a social worker who will tell him how many men and women to whom he has ministered are back in social life competent to take up its duties.

The Social Service Department of a hospital is used by physicians and administrators who have ideals and who strive for the betterment of social conditions by prevention of disease.

The Out-Patient Department of a hospital is the strategic point from which to work. Here the social vorker sees the patient with the physician and gets his medical opinion. She visits the home, knows its qualifications or limitations, she gets in touch with other agencies interested, and in consultation with the physician decides upon the best course to pursue for the benefit of the patient and society at large.

No outside agency can become responsible for duty that should be ours. Therefore, a hospital that is socially alive will support its own Social Service Department and extend to the patients in their homes the service they require.

We have twelve clinics and only two in charge of social service workers—these two are pre-natal and psychiatric clinics.

In these two divisions we know our patients, we know where we succeed and where we fail; we can tell the community what we require to make our service show results. We find that we need further institutional care for the defective, and, more than that, we know that our feeble-minded women are being exploited and that public sentiment is not strong enough to enable the courts to protect society by protecting her; we know that owing to this the hospital is crowded with a humanity diseased and dying with the offspring of this humanity. We know that owing to economic and war conditions that the housing conditions of Toronto are going from bad to worse, that while we have not many tenements there are many times five or six families in one house, often a family in every two rooms and sometimes in one room. We are asking for the mothers of babies born in these houses that convalescent care of three weeks be given following two weeks hospital care. These are conditions that simply must be changed when the war is over if we are to prevent disease.

Some of the things we do not know—how much industrial disease

we have that might have been prevented; how much is due to industry or to bad habits of patient, which, by instruction, might be overcome; how often the heart cases return to the hospital that by conscientious follow-up work might be prevented; how much preventive work might have been done by following the syphilitic cases and instructing the families; how much good might have been done by follow-up work in eye and ear clinics, etc.

Sickness, like poverty, bears the brand of inefficiency. Why should a young city in a new country have full institutions for the sick in body, mind, and estate? In Boston, a city of about equal size with Toronto, the Massachusetts General Hospital requires only half the bed capacity, but administers to the need of over three times as many persons in the Out-Patient Department. In the same city The Boston Dispensary does a like service to another multitude of people.

With our large in-patient population and small out-patient we administer medical relief at maximum cost to the city. A more serious result is a lowering of personal responsibility of the individual family and a familiarity with the ease with which they may procure institutional relief. Until the board of managers and physicians realize the place of the social worker in preventive medicine, no great progress will be made. By intensive follow-up work from the Out-Patient Department the social service worker creates in the homes the desire for health and a spirit of independence. She explains in simple language the nature of the disease and the physician's plan of treatment, so that there may be intelligent co-operation between physician and patient. She tries to instill the gospel of fresh air and sunshine, of pure living and clean thinking, even in the midst of unsocial environments that are a disgrace to civilization. The medical world cannot lag behind other reformers in this war against social inequality.

The workers of the world are entitled to justice and then they will not need charity. They will receive a living wage and can pay for a decent environment and the privilege of a happy home and a place in society.

ROUTINE TREATMENT OF TYPHOID FEVER IN THE TORONTO GENERAL HOSPITAL

By M. Gertrude Stovel

By the routine treatment of typhoid fever we mean, that treatment which was instituted by the permanent medical staff for public ward patients, and not the many and varied kinds of treatment used by the physicians of the semi-public and semi-private patients who are treated in the hospital. That treatment has been, in the majority of cases, one of starvation and sponges. The patients have made good recoveries,

but have not gone home as well nourished as the patients who have received the routine hospital treatment.

It is known that the treatment of typhoid fever is for the most part a nursing problem, so we give first the nursing care, which is as follows:

Each bed patient has a soap and water bath every morning and this takes the place of a sponge if a sponge is indicated.

A simple enema every morning, if necessary, that is, if there has been no defacation for twelve hours. When there is diarrhoea an enema is very often of value.

The mouth is cleaned before each nourishment with a wash made of equal parts of carbolic 1-100 and glycothymoline, and is rinsed with water after each nourishment.

Sponges are given every four hours for a temperature of 103 deg. This, we know, is all wrong. According to the new theory every typhoid patient should be sponged every four hours during the active stage of the disease, regardless of temperature. We are now taught that we sponge, first, to stimulate the action of the skin in eliminating toxins; second, to improve the circulation; third, for the sedative effect on the nervous system and not, as most of us were taught, to reduce temperature.

The method of sponging now used is very effective, and in all but four or five cases the patients have enjoyed them, in fact a few have actually asked for them. They are refreshing and almost always followed by sleep. To some of us who have experienced a great piece of ice swaddled in a towel and rubbed vigorously over our chests, or a wet thing creeping down our legs following the course of the veins, it appeals very strongly to be wet all over at the same time.

Cold Sponge: To the bedside is brought a foot tub one-half full of tepid water, also a small basin of ice for compresses for the head, and all other articles necessary for giving sponge. The patient is covered with a sheet and the top bed clothes are folded neatly to the foot of the bed. A sheet and large emergency rubber are put under the patient, leaving sufficient sheet at one side to fold over the patient when the sponge is finished. A binder is used and is fastened on one side, so that when the patient is turned during the sponge the binder will fall behind her. Then remove the gown. A cold compress, preferably of Turkish towelling, is placed on the head and changed every two minutes during the treatment. A hot water bottle is placed at the feet. The sheet covering the patient is then removed and gentle friction is given for about two minutes before sponging is begun. The anterior surface of the body is sponged for fifteen minutes, using a large sponge of Turkish towelling well filled with water. Squeeze the water slowly from the sponge with one hand and with the other apply

a gentle friction to the entire body except the abdomen. Occasionally mop the water from the rubber with the sponge and by squeezing the latter return the water into the tub. The water is kept at the required temperature by adding ice. The patient is then turned on one side and the posterior part of the body is sponged for five minutes. Mop up the water on the rubber, unpin the binder, and remove it with the rubber and at the same time wrap the patient in the under dry sheet and give friction through this until the patient is dry. Then cover her with a light blanket and remove the sheet. Give an alcohol rub, replace the gown and arrange the top bed clothes, leaving the blanket on until a good reaction takes place. The sponge lasts twenty minutes. Contra indications for sponging are haemorrhage and severe abdominal pain.

A certain routine is followed in medication also, although all medication is ordered by the physician for each patient. If it is not later than the tenth day, 2 grains of Calomel and one-half an ounce of Salts may be given and the Salts repeated for four or five mornings. Salol grs. 5 and Urotropin grs. 5 are given every six hours. A tonic mixture of Liquor Strychnine is given three times a day. Whiskey and Caffeine Sodium Benzoate are given for feeble heart action. For nausea, a Bismuth mixture is used, and for diarrhoea usually two or three doses of Lead and Opium Pill.

The following schedule covers the diet of the average patient: During the day nourishment is given every two hours and during the night every four hours. At least two thousand calories given in twenty-four hours. It is not easy to make patients take this much, especially during the first three weeks, and often it is impossible. Some cannot assimilate two thousand calories and the result is nausea and diarrhoea, while others can and are eager to take even more than that. Some can hardly be roused to take a drink, and to these we give fluids with a very high caloric value, making it possible to give nourishment in small quantities. Lactose has been used to a great extent for these patients, as it can be added in large quantities to milk and other fluids without making it too sweet to be palatable. Fluid and semi-solid food is not usually given until the tenth day of normal temperature, but we have given soft diet as early as the fifth day without bad effects. This has been where the patient was extraordinarily hungry. We have found that the appetite is a fairly good chronometer for indicating a slight and careful increase in diet. It has been found that patients whose diet was increased before the tenth day had no more and no higher elevations of temperature than those who patiently and indignantly served the full ten days of intense hunger.

Water is given immediately after the nourishment and at least once again before the next; one hundred ounces to be given in twenty-four hours. Very few of the patients have been thirsty enough to

want that much and here again it is necessary to constantly worry them to take a drink. A jug of water beside the patient and tubing with a glass mouthpiece has been successful in different cases. This enables the patient to drink without the slightest exertion.

Treatment for haemorrhage is always much the same: All medication is discontinued and nothing is given by mouth but small amounts of chipped ice. Absolute rest is essential, and to secure this Morphine is very often given. Ice coils or light ice bags are applied to the abdomen. Calcium Lactate and Horse Serum are usually ordered.

The Widal Reaction has not always been positive, and for this reason the physician disregards a negative reaction if the other symptoms and findings give positive evidence of typhoid fever.

Of the thirty-five public ward patients treated during the last four months six had been inoculated with anti-typhoidal vaccine, the time of inoculation having been from five days to two weeks before the onset of the disease.

THE PSYCHIATRIC CLINIC

By Marjorie H. Keyes.

To-day many people are awake to the realization of the public responsibility for the prevention of feeble-mindedness. The present public provision for the mentally deficient is utterly inadequate and the time for some comprehensive action has arrived.

In Toronto, where this matter became so urgent, a clinic was established in the Toronto General Hospital under the personal supervision of Dr. C. K. Clarke and is associated with the Social Service Department.

The first clinic was held on April 8th, 1914, two adults and two children attending. Since then about 1,486 cases have passed through this department. Some have been placed in institutions, where they will be well cared for and trained to a degree, and in some instances taken from a community to which he or she has been a menace. Not only have the Juvenile Court, the Board of Education, and charitable institutions sought its advice, but many private individuals have come here for assistance. The cases range from the lowest grades of idiocy to Dementia Praecox and moral deviation.

The registration of the feeble-minded at the clinic makes possible regular visitation of each defective who needs oversight by a social worker. At the home she secures a full account of the environment, the developmental history of the patient, learns the specific stress to which he or she has been subjected, and his behaviour at home, at school, in the neighborhood, or at business. It is often necessary to confer with neighbors, clergymen, school principals, as well as parents

regarding the history of these cases. Incidentally, the parent is pleased to think that the hospital takes such an interest in her child as to send a visitor to the home.

The social worker advises the parents as to the care and management of the defective and has an opportunity to inform the family, local officials, and school principals as to the peculiar dangers of these cases. Home visiting makes it possible to inform the parents of the necessity of lifelong supervision at home or the suggestion of placing the child in an institution where he would be properly cared for and trained.

GLEANINGS.

Dr. F. S. Minns, writing in *The Canadian Medical Association Journal* on "The Method of Dealing With Tuberculosis in the Public Schools of Toronto," says in part:

The city is now divided into districts with a medical inspector and two nurses in charge of each district. The medical inspector and the nurses of each district are expected to obtain an accurate knowledge of the prevalence of disease, sanitary conditions, home environment, and the number of indigent families in the district. The investigation and control of positive and suspect cases of tuberculosis among school children is being carried on with the assistance of the whole staff by one of the assistant medical inspectors specially qualified to undertake this work. The work is being developed in proportion to its importance and magnitude. All known positive cases are recorded and every exposed and suspect child is examined. The medical inspectors and nurses assist the special examiner by referring to him all exposure and suspect cases with a report of home conditions.

Extract from instructions to the staff regarding positive and suspect cases of tuberculosis.

"Cases naturally divide themselves into two classes: First, those without a history of exposure, and second, those with a history of exposure, that is, direct contact."

"All suspect cases without a history of exposure must first be examined by the school medical inspector, who, if he deems it necessary, will have a report sent in requesting an examination by the special examiner. Special consideration is to be given cases where an examination is requested by the parent."

"All suspect cases with a history of exposure should be reported and a notification will be sent stating the manner in which the case is to be followed up and examined."

"Reports of all new cases of suspect tuberculosis, and all old cases not as yet recorded with coloured stickers, should be sent in with your

daily records, on the form provided. In the event of not having a form, give all the information which is thereon asked for: name of school, family name, address, names of all the children of all ages in the family, present whereabouts and condition, history of contact or exposure, agencies interested, and your signature."

"Cases, which are reported from the office of the chief medical officer and having a history of exposure, are to be examined as soon as possible by the special examiner or at a chest clinic at one of the hospitals or dispensaries mentioned in the notification."

"Cases which are examined by the special examiner or at a chest clinic will have the results of the examinations reported to the medical staff of the school as soon as possible. If the child is advised to discontinue attendance at school the report will state this, and when advised to return to school after absence the child will be given a note to this effect."

"Cases reported by the special examiner, and no others, are to be recorded by the school medical inspector on the children's reference and physical record card with coloured stickers. These stickers are used according to a code supplied."

"Under the heading on the report, 'agencies interested,' the following are the four principal ones: the parent or guardian, school, family physician, and any recognized charitable organization in the order in which they are to be considered."

"A record of every child examined to determine if tuberculosis infection is present is kept in the office of the chief medical officer. In so far as possible the record of each family will be completed under the following heads:

Date of the special examination.

Names of all the children in the family.

Ages of all the children.

Family address.

Name of the school or schools that the children attend.

Brief history of the exposure—family, house, occupational, time, duration, degree.

Result of the tuberculin test.

Number of the x-ray when taken.

Pathological lesions.

Diagnosis, and by whom it was made.

A note as to whether the case has been registered or reported to the Board of Health.

A note stating by whom the child was referred for examination.

A note of the child's present physical condition, and of the home and social conditions.

A note of the recommendations re school and treatment.

A note of the termination of attendance or treatment.

"The work of the department is carried on in conjunction with the work of the family physician, dentist, the chest clinics at the hospitals and dispensaries, the various missions, the social service organizations, and the Board of Health. From these sources reports are received and acknowledged. The work is being developed and expanded in harmony with the existing organizations in order to reach the largest number of children possible, and as soon as there is reasonable ground for investigation to bring the timely aid which will ultimately be a great factor in lessening the prevalence of tuberculosis among school children—conservatively estimated at twenty-five per cent—and as a direct consequence, among adults."

"Information may be obtained at any time by the members of the staff from these records."

"When the 'agency interested' is a physician the following form letter is sent to him and no further steps are taken in the case until a reply is received."

Toronto.....

Dr.....

.....

Dear Doctor:

I have received a report that you are interested in the ..... family.....St. The report states that the children attending school have been exposed to an infection with tubercle baccili. We are desirous of gaining some definite knowledge regarding this infection, the control of which is one of the aims of medical inspection of public schools. We ask your co-operation in one of three ways:

First: That you will send a certificate giving your examination findings, and state whether the case shows sufficient signs and symptoms to make a clinical diagnosis in the case of,

....., age .....

....., age .....

Second: Or that you will express your willingness to have the children examined at school by the school special examiner, Dr. F. S. Minns, who will send you a report of his examination.

Third: Or that you will express your willingness that arrangements be made by the school nurse for an examination at a chest clinic at one of the hospitals.

Trusting to hear from you soon in regard to this matter, I remain,

Yours sincerely,

ALEX. MACKAY,

Chief Medical Officer.

This special work has been carried on for a year and a half. During this time a large number of letters have been written to the doc

tors. The response in almost every case has been prompt and in all cases a ready will has been shown, to assist in the work in every way. Every doctor has experienced the difficulty of getting permission to examine all exposure and suspect cases which he meets with in his private practice and he has been found to welcome the aid which will enable him to render service to those under his care.

Contagious diseases reported to the Municipal Board of Health from all sources are daily reported by the Board of Health to the chief medical officer. These cases are then reported by telephone, and by mail on special forms, to the principal and to the medical inspector of the school in the district in which the cases live. Cases of tuberculosis reported from the Board of Health, however, are for several reasons forwarded to the school medical inspector only. The school nurse then discovers whether there are any school children in the house with the case. If school children are found a complete record is sent in on the form provided, and where there are no school children a report to this effect is returned. The results of all examinations and the recommendations in each case made by the special examiner are reported to the Board of Health. In the case of tuberculosis adults examined at the clinics at the Toronto General, St. Michael's and the Western Hospital, instructions are given to the patient that all the children exposed are to be brought to the chest clinic at the Hospital for Sick Children for examination irrespective of the presence or absence of symptoms of tuberculous infection. The results of the examinations and the recommendations made by the examiners at the hospital are reported to the medical staff of the school which the children attend. The Board of Health and the Board of Education nurses therefore receive the same information about the cases. This tends in a measure to prevent overlapping of medical, nursing, or relief work. Many new cases other than the above are continually being found by the nurses in their work in the school or while making visits to the homes, and these cases are reported to the special examiner.

The examinations made in the schools are arranged by the school nurse who gets a written consent from the parents for the examination. The nurse also endeavors to have the parent present. This is of considerable help in obtaining an accurate history and it insures the prompt carrying out of recommendations. A tuberculin test is made for each child examined—either a Von Pirquet or a Mantoux.

Cases examined are divided into three groups: positive, negative, and cases of doubtful evidence. Cases in the third group are kept under observation and re-examined until placed in either the positive or negative group. The positive cases are sub-divided into two groups—open and closed cases. The closed cases are those which have given positive tuberculin reactions with clinical evidences of tuberculosis.

This branch, as are all the branches of medical inspection work, is carried on to help each child of school age to attend school the largest number of days. This is possible for a healthy child only. The natural question which arises is: "What are we doing for the child who is found with signs and symptoms of tuberculosis?" The large majority of them are found to have one or more of the following more common pathological lesions, viz.: sore eyes, defective teeth, discharging ears, enlarged cervical, mediastinal or bronchial glands, diseased bones, joints, or skin, or some pulmonary involvement. Varying grades of anaemia and degrees of debility with frequently recurring colds are common conditions. In many cases treatment of the non-tuberculous conditions is the best treatment for the tuberculous. Parents are advised to take their children to the family dentist. If unable to afford to do so, the children are treated at one of the schools or municipal dental clinics. For ear, nose, or throat treatment, the children are referred to the family physician, or to one of the hospitals. The correction of these defects in many cases is all that is necessary, with the addition of general measures to improve the general health. Tuberculin treatment is advised for suitable cases and is given by the family physician, or at the chest clinic at the Hospital for Sick Children. We endeavor to have open cases among adults removed from the child, or the child from the home. A large number of closed cases are sent to the Preventorium of the Daughters of the Empire for a period of one to four months. Their education is carried on by a teacher provided by the Board of Education while in this institution. The admissions to this institution are granted at the chest clinic at the Hospital for Sick Children. The child sent to the Preventorium is one who, after repeated examinations, is considered safe to mingle with other children and to be re-admitted to school. During the six warmer months of the year, the Heather Club Chapter of the Daughters of the Empire, with the co-operation of the Hospital for Sick Children, are able to care for fifty children at the Lakeside Home. During this period the Board of Education also maintains two forest schools, one in Victoria Park, the owner, Mr. H. P. Eckardt, having generously given the use of the grounds and buildings for the past two years, and one in High Park, a corner of which is being used with the consent of the city council. The attendance at each of the two forest schools averages one hundred. Inasmuch as the schools are intended for children physically sub-normal and presumably more susceptible to secondary infection, great care is exercised to select such cases only in which infectious pathological conditions are quiescent. Frequently it is necessary to cope with bad environment, poverty and ignorance, and here the agencies of pure air, selected diets and education, are the remedies par excellence. Open cases, pulmonary or otherwise, which are a menace to

others are excluded from all schools, and the cases, adult or child, among the poor, are visited by the Board of Health nurses. In some instances the children are referred to the Queen Mary Hospital at Weston, where there is accommodation for about eighty children.

This method of dealing with tuberculosis as it exists amongst the children in our public schools and the careful study and supervision of the individual child during school life will, it is hoped, produce good results. The statistics obtained, moreover, should be valuable to the medical profession in the general study and prevention of tuberculosis.

The Queen's Nurses' Magazine gives the following:

"New Zealand has reduced her infant death rate to 25 per 1,000; a little French Commune enjoyed a zero mortality for ten consecutive years. Wherever special effort has been made, commensurate results have followed: a large manufacturing centre in one year reduced its rate from 139 to 36; a women's organization had under its care for five years 1,500 women—in the last three and a half years not one miscarriage occurred and the infant death rate fell to 20 per 1,000.

The new Act gives full authority for all the measures necessary towards securing in every administrative area of the land a zero mortality rate: regulations have been issued regarding the best methods of working; one-half the cost has been offered. Will the lead be followed? Not everywhere, can it be expected; for public opinion is not sufficiently educated and public support is essential."

The nurses who go into the homes, whether public health nurses, school nurses, or visiting nurses, have the great opportunity of educating public opinion so that the necessary support will be forthcoming. These nurses come near to the mothers and have the wonderful opportunity of establishing the co-operation of these mothers, which is most essential.

The Mothers' Friendly Club in Griffen Town, for which the nurses are responsible one night each month, is in a very flourishing condition. This year the members have officers elected from among themselves and they are all very keen. The first meeting in January took the form of a Christmas supper, after which games were played and some excellent music contributed by friends. A log fire added greatly to the cheeriness of the scene, the club room being very prettily decorated with greenery, flags and lanterns.

In February, Mrs. Read, on whom so largely the success of the club depends, and who is most untiring in her efforts to help her poorer sisters, gave an illustrated lecture of her life and work in Portuguese East

Africa and sang in the native language. The pictures were excellent, being chiefly of her own taking. At the close she showed what wonderful things could be done with old stockings, the tops of which make good petticoats or drawers for children. "Useful Hints" has become a great feature of the club.

In a preliminary report in the *New York State Journal of Medicine* Dr. T. Wood Clarke, of Utica, N.Y., gives his experience covering a period of two years in treating pneumonia in children by the use of hexamethyleneamine. Marked improvement is usually noticeable in a few hours. The dose is grs. II every 2 hours. Dr. Clarke has also used hexamethyleneamine in smaller doses in cases of influenza, measles, and whooping-cough with gratifying results.

A Marseilles doctor recommends the following method as efficacious to prevent wound infection. It consists of cleaning wounds with petrol before applying iodine; petrol may be obtained anywhere. "Wash your hands with petrol; they will be clean, almost aseptic. Wash the tissue round the wound with petrol, and you will bring off several layers of dirt, even from skin which looks clean. Then apply tincture of iodine and a sterilized dressing, and you will avoid a good deal of secondary infection. Petrol is not irritating to the skin or even to the wound; an experience of more than five months' use several times a day on large wounds and on my hands has not shown any ill effects. The one disadvantage is its disagreeable smell, and it must never be used near a flame. The petrol and the iodine should not be used too freely. If the surrounding tissues are red or slightly inflamed, use an ointment of resorcin and oxide of zinc, 10 parts of each in 100 parts of vaseline." The doctor recommends in severe wounds the washing not only of the wound, but of as much of the surrounding tissue as possible; for instance, in a leg wound wash from the groin to the toe nails.—*Una.*

THE FACTOR OF POVERTY IN SANITATION

The factor of poverty in sanitary problems was discussed in Washington, Nov. 26, by Surgeon General William C. Gorgas, whose success in cleaning up Havana and the Panama Canal zone have brought him recognition as America's leading sanitarian. His audience was the Clinical Society of Surgeons, assembled in their twenty-fourth annual meeting. Dr. Gorgas said, in part:

"Such sanitary work as is necessary in the tropics is inexpensive, but measures directed against special disease are not the greatest good that can be accomplished by sanitation.

"Before these great results that we can all now see are possible for the sanitarian, we shall have to alleviate more or less the poverty at present existing in all civilized communities. Poverty is the greatest of all breeders of disease and the stone wall against which every sanitarian must finally impinge.

"During the last ten years of my sanitary work I have thought much on this subject. Of what practical measure could the modern sanitarian avail himself to alleviate the poverty of that class of our population which most needs sanitation? It is evident that this poverty is principally due to low wages; that low wages in modern communities are principally due to the fact that there are many more men competing for work than there are jobs to divide among these men. To alleviate this poverty two methods are possible, either a measure directed toward decreasing the number of men competing for jobs, or, on the other hand, measures directed toward increasing the number of jobs.

"The modern sanitarian can very easily decrease the number of men competing for jobs; if by next summer he should introduce infected stegomyia mosquitoes at a dozen different places in the southern United States he could practically guarantee that when winter came we would have several million less persons competing for jobs in the United States than we have at present. This has been the method that man has been subject to for the last six or seven thousand years, but it does not appeal to me, nor, I believe to yourselves. This method is at present being tried on a huge scale by means of the great war in Europe. I do not think that I risk much in predicting that, when this war is over and we shall have eliminated three or four million of the most vigorous workers in Europe, wages will rise, and for a long time no man will be unable anywhere in Europe to get a job at pretty fair wages.

"But I am sure that every sanitarian would much rather adopt measures looking toward the increase of jobs rather than, as we have done in the past, submit to measures that decrease the number of competitors for jobs.

"I recently heard one of the members of the Cabinet state that in the United States 55 per cent. of the arable land, for one reason or another, is being held out of use. Now, suppose in the United States we could put into effect some measure that would force this 55 per cent. of our arable land into use. The effect at once would be to double the number of jobs. If the jobs were doubled in number wages would be doubly increased. The only way I can think of forcing this unused land into use is a tax on land values.

"I therefore urge for your consideration, as the most important sanitary measure that can be at present devised, a tax on land values."

VISIT OF A SCHOOL NURSE

"One day I decided to call upon a small boy of six years who had been absent from school and was reported to be ill. It turned out that, as one can almost guess (this year), that he had 'the measles,' but before gaining the knowledge of that fact the following conversation took place:

" 'Good afternoon. I am Miss —, the nurse from the school, etc.'

" 'Weel, I'm prood to ken ye. Oor wee Sam'l is awfu' ta'en up wi' ye.'

" 'Well, I'm glad of that. I have not lived in vain if Samuel likes me.'

" 'Weel do you ken, I've had an awfu' tribble wi' Sam'l!'

" 'How's that?'

" 'Sin' ever ye cam' tae the schule he was aye carryin' on aboot a teeth bresh! "Sam'l," say I, "whit w'uld ye do wi' a teeth bresh?" "Bresh me teeth, mither," says he. "Weel, but Sam'l, they's oney but ye'r first teeth." "First or last, mither," say he, "I maun bresh them tae keep them clean, fur they smell bad and there's no better than nasty garbage on them!" Well, wull ye believe it, he kep' on till I wis fair sick at me stummic and I maun e'en gang doon the toon and purchase a teeth bresh fer every yin o' the fam'ly, and there we staun' of a mornin', will ye believe it, all staun'in' like a lot o' ninnies breshin' oor teeth! He carried on sae muckle aboot odours, dert, garbage and sooch that we cudna eat oor meals wi' relish!'

"This is an instance of the education of the family by means of instruction given to a six-year-old boy in the school class room."

CORRESPONDENCE

To the Editor of The Canadian Nurse:

Dear Madam: Can any of your readers kindly supply replies to the following enquiries:

1. (a) Do any of the large general hospitals of Canada provide post-graduate courses for nurses from small or from special hospitals? (b) If so, what are the usual regulations regarding salary, term of service, etc.?

2. Please give addresses of some Canadian maternity hospitals and terms of training. Is remuneration given during training?

3. Does the "Victorian Order of Nurses" accept nurses graduated from hospitals of less than 25 beds? Does one have to pass an examination (technical) to become a "Victorian Order Nurse" or an Army Nursing Sister?

4. Are nurses who have passed entrance examinations of the Province of Manitoba or of Nova Scotia eligible for membership in other Provincial Nursing Associations?

Editorial

NURSING SISTER ELSIE G. ROSS

We deeply regret having to chronicle the death of Nursing Sister Elsie G. Ross, at Toronto General Hospital on February 26, 1916, of pleuro-pneumonia.

Miss Ross was a graduate of Toronto General Hospital Training School for Nurses, and had been on military duty since the outbreak of the war, at the Exhibition Camp and Convalescent Hospitals, Toronto.

Miss Ross was a most painstaking, conscientious nurse, who will be sorely missed from the ranks. Her gentle disposition and faithful devotion to duty endeared her to her patients and to all who knew her. Her life was the sacrifice she laid on the altar of her country. Her name should have a place on her country's honor roll, for no soldier could give more.

To her bereaved family, her classmates, and her friends we extend our most sincere sympathy. "She being dead, yet speaketh."

THE FRENCH FLAG NURSING CORPS

Our readers will remember that the Canadian National Association of Trained Nurses sent ten nurses to serve in this Corps in response to an appeal for assistance from Miss Grace Ellison, Supervisor of the French Flag Nursing Corps. We were afraid we were going to be under the necessity of regretting our prompt response to the call, for when our nurses landed in London they found they had to comply with regulations of which the War Committee had heard nothing. This meant that only seven of our nurses reached France. The other three have since obtained positions as military nurses through the untiring efforts of the War Committee.

This seemed unfair, to say the least, and as the task of selecting the nurses and raising the funds for equipment and transportation had been no light one, the War Committee felt that a second unit could not be sent under such conditions.

But it seems that a letter of explanation had been lost, so that the very embarrassing complications which arose were really not the fault of the committee in London nor of the War Committee.

The War Committee has received a request for a second unit of six nurses, which they are setting about raising as quickly as possible. As the printed regulations are all in hand now, there will be no com-

plications this time, and it is hoped the unit will be ready for the first sailing.

A letter has been received from Miss H. M. McMurrich, R.N., of the first unit, who tells us that the nurses are very happy in their work, which had only been of a preliminary nature so far. Mrs. Fenwick writes that the Canadian unit is doing splendid work in France.

THE CONVENTION IN WINNIPEG

We had hoped to have some further information re the convention in Winnipeg for this issue. All the Associations will have noted the dates, however, and will be making their arrangements. The information will be forthcoming in our next issue.

UNDERMANNED INSTITUTIONS

Too frequently attention is directed to institutions, usually hospitals, that are undermanned, by the sacrifice of health and sometimes by the sacrifice of a life. Either sacrifice should not be necessary, should not be allowed. It is not right, it is not reasonable that a life or health, which is indeed very life, should be the price paid to restore others to normal health.

Too often it is a case of expense versus health. The authorities refuse to authorize the expense with the result that someone's health must be the sacrifice. This is not economy. It is quite the reverse. It shows a glaring lack of foresight and unpardonable waste—of someone else's health. The authorities are not touched. They do not seem to care. They only study the balance sheet. That must be right, no matter who pays the price.

It is high time the authorities took some time to study the need of conserving life and health—the life and health of the workers in our hospitals. It is a subject worthy of study, and the result might be beneficial to the students and to the workers too.

THE GRADUATE NURSES' ASSOCIATION OF ONTARIO.

(Incorporated 1908.)

President, Miss Kate Madden, Supt. of Nurses, City Hospital, Hamilton; First Vice-President, Mrs. W. S. Tilley, Brantford; Second Vice-President, Miss Kate Mathieson, Supt. Riverdale Hospital, Toronto; Recording Secretary, Miss E. McP. Dickson, Supt. of Nurses, Toronto Free Hospital for Consumptives, Weston; Corresponding Secretary, Miss Isabel Laidlaw, 137 Catherine St. N., Hamilton; Treasurer, Miss E. J. Jamieson, 23 Woodlawn Ave E., Toronto.

Directors: Jessie Cooper, Ina F. Pringle, J. G. McNeill, J. O'Connor, E. H. Dyke, L. M. Teeter, M. J. Allan, M. L. Anderson, S. B. Jackson, Isabel R. Sloane, and G. Burke, Toronto; Mrs. Reynolds, Miss Simons, Hamilton; Bertha Mowry, Peterboro; C. Milton, Kingston.

The Canadian Government has received notice from London that the Secretary of State for Foreign Affairs has been informed by the United States Ambassador, that the Turkish Government desire that in future remittances of money not exceeding five pounds from private persons for British prisoners of war in Turkey should be despatched to the International Red Cross Committee, at Geneva, for transmission to the Ottoman Red Crescent Society, at Constantinople, by whom payment to the recipients will be effected and a receipt returned to the International Committee at Geneva.

Letters and parcels should also be sent to the International Red Cross Committee, at Geneva, for transmission. Such letters and parcels are post free. Money should be remitted by International Money Order, which can be obtained at any Post Office, and which should be made payable to the International Red Cross Committee at Geneva, and sent on with full name, number, and regiment of the prisoner of war to whom the money is to be paid.

Information has also been received from the United States Ambassador that prisoners of war in Turkey are now allowed to write only one letter a week, limited to four lines, and that this regulation applies also to letters addressed to them. Letters of greater length will not be delivered.

"Dr. Emmet Holt has spoken of the infant welfare station established by Budin, in Paris, in 1892, and the milk depot established two years later by Dufour, as 'really marking the beginning of the modern movement for the reduction of infant mortality. They have spread all over the civilized world and have proved to be, when properly conducted, one of the most effective agencies, if not the most effective agency, known for the reduction of infant mortality.' "

"New Zealand has long had the lowest infant death rate in the world and more than any other country New Zealand is working to reduce its infant death rate still further. This saving of babies' lives has progressed most markedly since the New Zealand Society for the Health of Women and Children began in 1907 its instructive nursing.

"The nurses of this society—called 'Plunket nurses,' from the former governor and his wife, who assisted Dr. Truby King in organizing the society—work from some seventy centres scattered through the dominion, and visit periodically all the neighboring towns and outlying districts to give advice and instruction in matters pertaining to the hygiene of motherhood.

The services of the nurse are at the disposal of every member of the community, rich and poor, and especial emphasis is laid on the value of her advice and help to expectant mothers. She does not, however, undertake the daily care of sick people, as her primary aim is educational. When the visit of the Plunket nurse is expected in a community the local committee arranges for her to hold mothers' meetings and demonstrations of baby care, in addition to class room talks and home visits. Correspondence with mothers in country districts too remote to be visited often is also a part of her duties. The society further maintains at Dunedin the Karitane-Harris Hospital for babies and mothers, which is primarily a school for mothers.

" 'The society is less concerned in reducing the death rate than in improving the health of the people. As a health society, we are more interested in firmly establishing the all-round fitness of the 24,000 or

25,000 annual new arrivals who will live than we are in reducing the potential deaths from 2,000 to 1,000. However, the problems are practically identical, since the simple hygienic measures which tend to prevent death in babyhood are also the measures which lay the foundations of strong and healthy minds in sound, enduring bodies for those who survive to be our future men and women.'

"This educational work by a volunteer society supplements in New Zealand a system of public health work by the Government, which includes a complete registration of births, a corps of district nurses distributed throughout the country, maternity hospitals in the cities and maternity wards in many of the country hospitals, and strict regulation of midwives, with the enforcement of a penalty for the occurrence of septic cases."

Plans for the nation-wide Baby Week, proposed by the General Federation of Women's Clubs, for March 4 to 11, have extended beyond the United States. A women's club in the British West Indies has just written to the Federal Children's Bureau for information about what Baby Week means and expects to initiate a local campaign. Several Canadian have been heard from, too, including the Saskatchewan Commissioner of Public Health.

The Philippines will take part in the celebration if the plan of a Manila woman's club is carried out. By special request the Children's Bureau has sent its Baby Week bulletin to Valdez and Nome, in Alaska, and to two of the Indian reservations in Western States.

The local plans for Baby Week vary in the 2029 communities from which the Children's Bureau has had inquiries. For instance, Wisconsin has initiated a state-wide campaign, in which especial emphasis is placed on adequate nursing care and instruction for prospective mothers. In Nebraska, a child welfare exhibit is being prepared by the women's clubs of Omaha and Lincoln, which will travel about among the clubs throughout the state after the Baby Week in those two cities is over. One town in Maryland, which is going to have a birth registration day, announces that an enterprising merchant has promised to give a tooth brush to every mother who goes to the City Hall to find out whether her baby's birth is registered. Another community is having a competition for the cleverest window plan for Baby Week publicity.

The Victorian Order of Nurses for Canada offers a post-graduate course in district nursing and social service work. The course takes four months, and may be taken at one of the Training Homes of the Order: Toronto, Ottawa, Montreal, Vancouver. For full information apply to the Chief Superintendent, 578 Somerset Street, Ottawa, or to one of the District Superintendents, at 281 Sherbourne Street, Toronto, One.; 46 Bishop Street, Montreal, Que.; or 1300 Venables Street, Vancouver, B.C.

THE CANADIAN NURSES' ASSOCIATION AND REGISTER FOR GRADUATE NURSES, MONTREAL

President—Miss Phillips, 750 St. Urbain St.

First Vice-President—Miss Colley, 23 Hutchison St.

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Secretary-Treasurer—Miss Des Brisay, 16 The Poinciana, 56 Sherbrooke Street West.

Registrar—Mrs. Burch, 175 Mansfield St.

Reading Room—The Lindsay Bldg., Room 319, 512 St. Catherine St. West.

The Canadian Nurses' Association has rented a house on Dorchester Street West, to be used as a clubhouse, and hopes to be settled in the new quarters in April.

Miss McBeath is steadily improving and hopes to be able to be moved to her home in New Brunswick shortly.

ON THE HABIT OF ATTENTION

Who has not, in walking through the streets with a child, been struck by the extraordinary nimbleness of the child-mind. Nothing escapes the restless little eyes and ears. The young brain, like a silvered ball, mirrors all surrounding objects, and the impressions are equally superficial in either case. It is the part of a wise teacher to train the child's habit of mere passive reception of a thousand images, up to the power of steadily directing and fastening the attention upon one; and to do this at the bidding of his own will, in independence of the stimulus, the interest, or impressiveness of the object. Such a mental habit is one of the most precious that anyone can acquire. There is no intellectual strength without it, no solid acquisition of knowledge, no invention, no prudent management of men and things. Alas! the number of wise teachers at work in the world is mournfully small. Are you, my reader, one of the happy ones whose childhood has been passed under the kindly influence of such wise direction, so that attention has become a fixed mental habit with you? Thank God many times if it

is so! The habit of attention, of immense value to all manner of persons, is eminently so to a Nurse. Without it there can be none of that accurate observation of facts which is so indispensable a qualification for all who wait upon the sick. Our memory, too, in large degree depends upon it. We pity ourselves as the victims of bad memory; we shall do better to scold ourselves for inattention, for, as a rule, forgetfulness is but the consequence of mental listlessness or wandering.

Beyond this, a habit of attention brings the power of utilizing broken fragments of time. A nurse cannot count many minutes in the day her own, and the difficulty is to turn them to any good purpose when they come. In so many cases the time is spent in giving chase to truant thoughts which are off to the four corners of the earth. And yet five well-spent minutes daily would carry us in no long time through more than one great and noble book.

To these pleas for the habit of attention let me add this—it enables us to rise superior to the minor ailments of our daily life—the headache, the depression, the langour or malaise, which in these days are the occasional trial of so many. It is in the power of a trained will to put these things resolutely out of our consciousness and to work on as if they did not exist. A by no means rare and always beautiful sight it is to see great things, great schemes, managed and carried successfully through by persons of feeble frame and little health, who steadily refuse to allow their minds to dwell upon their ailments, who forget that they are invalids, and make others forget it too, and by force of will turn their whole strength to interests outside themselves. It is possible, even, to master acute pain by a similar process. Dr. Carpenter tells us that, before the introduction of chloroform, patients sometimes went through severe operations without giving any sign of pain, and afterwards declared that they felt none—having concentrated their thoughts by a powerful effort of abstraction on some subject which held them engaged throughout.

There are even higher uses of attention, in matters of deep moral import such as the control of thoughts, the ability to reject at will thoughts which our conscience or our judgment condemn, and choosing others. And in the duties of religion, such as prayer, meditation, and communion—those great and solemn actions, whereby we dwell in God and God in us—how much is gained or lost according as we are able to bring to bear a mind more or less concentrated upon what is before us. There are few who are not at times teased and disheartened by the uncontrollable rebellion and restless flitting of their thoughts at those moments of great opportunity. "A proper and effectual remedy for this wandering of thought," says Locke, "I would be glad to find. He that shall propose such an one would do great service to the studious and contemplative part of mankind, and perhaps

help unthinking men to become thinking. I must acknowledge that hitherto I have discovered no other way to keep our thoughts close to their business but the endeavoring as much as we can, and by frequent attention and application getting the habit of attention and application." Single efforts at attention will slowly build the habit, and the habit is worth much effort and many a weariness. Said Kingsley of himself, "My greatest help in life has been the blessed habit of intensity. I go at what I am about as if there was nothing else in the world for the time being." In other words, Let us do one thing at a time, and put our whole mind and strength into it.—*Misercordia.*

THE CAMPAIGN AGAINST CANCER IN NEW ENGLAND

The New England States generally show a higher death rate from cancer than any other group of States. This does not mean that New England people are more susceptible to this disease. Cancer is a disease of later adult life, and it is well known that in parts of New England there are more old people proportionately to the population than in many other regions. Nevertheless, the death rates recently published by the U. S. Census Bureau have stimulated much activity in these States in the educational campaign for the control of malignant disease.

What are the facts upon which this movement is based? According to the report of the U. S. Census Bureau, in 1913 there were 49,928 deaths from cancer in the registration area of the United States, corresponding to a death rate of 78.9 per 100,000 of the population. All the New England States have individual cancer death rates much higher than this. Connecticut's rate, which was the lowest of any of the New England States, was 85.1. Vermont's rate was the highest with 111.7, while the rates of the other States were correspondingly high. Maine having a rate of 107.5, New Hampshire 104.4, Massachusetts 101.4, and Rhode Island 93.3. When these figures are compared with those of Kentucky, with a rate of 48, they seem indeed very high. They mean that 6,817 people died in 1913 in New England from cancer. But it does not necessarily follow that cancer is more common in New England than elsewhere. The Census Bureau attributes the high cancer death rates in certain districts to the relatively high age distribution of the population and the negligible amount of immigration. Translated into everyday terms this means that in New England the proportion of people over forty years of age, or at the cancer age, to those under forty, and so less liable to cancer, is greater than in other places. Yet there is no doubt that the cancer death rate in New England, as

well as in other parts of the country, is much higher than it ought to be. Without question a large percentage of cancer deaths can be prevented by early recognition of the symptoms and prompt recourse to competent surgical advice and treatment. Cancer is not a hopeless incurable affection, as so many people wrongly believe. Those who know the facts believe that if the public can be properly educated in regard to the early signs of the disease and will act on this knowledge, the present mortality should be reduced at least half and perhaps two-thirds.

That New England is awake to this opportunity of saving lives is evident from the activity in several States. To protest against taxation without representation the patriots of Massachusetts dumped overboard the famous cargo of tea. Vermont medical men have become so concerned over the high cancer death rate of their State that they are going to hold a "tea-party" of another sort and attempt to dump overboard the high death rate from malignant disease. While their action is not so dramatic as that of the patriot raiders they hope to prove that through its great ultimate benefit to the community it will be almost as patriotic. The New Hampshire State Board of Health has recently published sound advice in its bulletin. In Maine an active committee of the State Medical Society is arranging public lectures and causing the publication of instructive articles in the newspapers. Massachusetts has a well-organized branch of the American Society for the Control of Cancer, with headquarters in Boston. The Vermont State Medical Society has arranged a series of public meetings to spread the bad news of the high cancer death rate and the good news of the hope of controlling the disease by earlier recognition and prompt surgical treatment. Morning, afternoon and evening meetings will be held on Tuesday, Wednesday, Thursday and Friday, June 8th to 11th, at Rutlaand, Burlington, Montpelier, and St. Johnsbury. The Vermont State Board of Health will send its secretary, Dr. Charles F. Dalton, to address each of these meetings, and the American Society for the Control of Cancer will be represented by Dr. Francis Carter Wood, Director of Cancer Research at Columbia University, New York City, and by Dr. J. M. Wainwright, chairman of the Cancer Committee of the Pennsylvania State Medical Society.—*Detroit Medical Journal.*

HOSPITALS AND NURSES

British Columbia

Word has been received in Vancouver that the name of Miss E. L. Craig, graduate of the Vancouver General Hospital, is among the list of those mentioned in dispatches by Sir John French, dated November 30, 1915. Those whom he recommends for "gallant and distinguished service in the field."

Miss Craig, who was working in Honolulu when war broke out went from there to England, where she joined Queen Alexandra's Imperial Military Nursing Service Reserve, and has been on active service ever since.

Miss E. C. Jordan's name also appears on the list. Miss Jordan went from Honolulu with Miss Craig.

Alberta.

The regular monthly meeting of the Edmonton Association of Graduate Nurses was held on Wednesday, January 19th, 1916, at 3.30 p.m., at the Y.W.C.A. rooms. The President, Miss M. Walsh, occupied the chair.

As it was the annual meeting, the most important business was the election of officers, which resulted as follows: President, Miss M. Walsh; vice-president, Mrs. Armstrong; 2nd vice-president, Miss Morkin; treasurer, Mrs. Lee; secretary, Miss Churchill; corresponding secretary, Miss A. Sproule.

At the close of the business meeting, held in February, in the palm room of the Hudson Bay Company, Mrs. Nellie McClung addressed the meeting.

Mrs. McClung spoke of the life of the nurse and the dignity of the position she holds. She advised the nurses to get together and be a club instead of an organization. "One thing we have to learn from our enemies is the true value of organization. They work in perfect unison in all their efforts and better results are naturally obtained."

Mrs. McClung stated that if the Empire was to be saved at this critical moment, the women must not get panicky. If the Empire was to be saved it must be saved by the women and the men. The men are doing all they can and the women must do the extras.

She advised her hearers to grasp every hour of the day, and live sixty minutes of each hour.

Miss Walsh, President of the Association, occupied the chair, and Mrs. McClung was presented with a bouquet of tulips. "A piece of Spring," she called them in expressing her appreciation.

Ontario

Peterboro: Miss B. M. Mowry, Superintendent of Queen Mary Hospital, and graduate of Nicholl's Hospital, who has been at Queen's

Hospital, Kingston, for several weeks, returned to Peterboro for a few days before leaving Canada. The Peterboro Chapter of the Graduate Nurses' Association of Ontario presented Miss Mowry with a gift and address as a slight token of the high esteem in which she is held by all. She expects to join the Peterboro nurses who have preceded her.

Mrs. David Miller (Miss Coleman), formerly Superintendent of Nicholl's Hospital, has been accepted for overseas service. Her husband has also enlisted as a private in the 93rd Battalion. We feel sure of most efficient service from both.

Our sympathy is with Miss Agnes Mercier, one of the city's district nurses, who is in St. Joseph's Hospital, and has undergone an operation for appendicitis.

Miss Reid is Acting Superintendent of Queen Mary Hospital during Miss Mowry's absence.

At St. Michael's Hospital, Toronto, on Tuesday, January 18, the Holy Sacrifice of the Mass was offered at the request of the alumnae association for the safety of the overseas nurses. The celebrant was the Reverend Father McGrath, of Schomberg, a former chaplain, and the music was rendered by the nurses' choir.

Miss Bertha Cunningham, S.M.H., '14, has joined the school nursing staff in Toronto.

Nurse Elsie G. Ross, of the Camp Hospital and of the Soldiers' Convalescent Home, died at the Toronto General Hospital on Saturday evening, February 26, 1916, from the effect of pleuro-pneumonia. Miss Ross was the daughter of Mr. Alex. Ross, of Stratford, Ont., and was well known and highly respected in Toronto medical circles, and her work among the soldiers in the camp hospitals at Niagara and Toronto was marked by faithful diligence and unselfish sacrifice.

As a tribute to her memory, the members of the Toronto Medical Academy have placed their building, 13 Queen's Park, at the disposal of the military authorities, where the funeral service was held on February 28th. A military funeral was arranged. A gun carriage bore the body from the academy to the Union Station, proceeding down University Avenue, accompanied by the band of the 74th Battalion. The burial took place at Stratford on Tuesday at 2 o'clock. Medical officers from the camp acted as pallbearers.

This is the first death among the nursing sisters at the camp, and was the first military funeral accorded to a nurse in this division.

The Graduate Nurses' Alumnae Association of the Owen Sound General and Marine Hospital held its annual meeting at the hospital on January 15, 1916.

The following officers were elected for the ensuing year: Honorary president, Miss Wood; president, Miss Forhan; first vice-president, Miss Muir; 2nd vice-president, Miss Beaton; secretary, Miss Web-

ster, 1030 4th Ave. West; treasurer, Miss Graham; assistant treasurer, Miss Simm.; flower and sick visiting committee, Misses Watson, Wardell, Simons and McLean; Red Cross, Mrs. Corbett, Miss Simm (sec.-treas.), Misses Cume, Beaton and McArthur; programme, Miss Beaton, Mrs. John and Miss Wardell; The Canadian Nurse representative, Miss McArthur, G. & M. Hospital. Regular meeting, last Saturday at 3 p.m.

The winter meetings have been used for the most part for the making of Red Cross supplies. Extra meetings were called for this work whenever a number of nurses were known to be off duty.

Miss F. Davis has completed her course in the G. & M. Hospital, and after a month's rest at her home in Tara will return to Owen Sound to do private nursing.

Mrs. Coghill (Miss Hambly) graduate of G. & M. Hospital, class '14, and lately Nursing Sister with the First Canadian Contingent, has returned from England and is visiting her parents at Hepworth.

Miss Wood, Superintendent of the G. & M. Hospital, attended the second hearing of the Graduate Nurses by the Royal Government Commission, on February 1, 1916, in the Parliament Buildings, Toronto.

Miss Anna M. Seeler, class '13, Orillia General Hospital, is at No. 3 Stationary Hospital, Lemnos.

Miss May Devitt, graduate Orillia General Hospital, class '15, has been appointed to the staff of the Ontario Government Hospital at Orpington, Kent, England.

The 1915 class of Orillia General Hospital are: Misses Isabelle J. Neilly, Florence E. M. L. Livingston, Ethel M. Watson, Eva M. Stewart, C. Rose May Devitt.

Miss M. Y. E. Morton, Superintendent of G. & M. Hospital, Collingwood, has joined the staff of the Ontario Government Hospital, Orpington, England. On the eve of her departure for Toronto Miss Morton was presented with a wrist watch and a cheque for fifty dollars. Miss M. McCullock, a graduate of the Collingwood G. & M. Hospital, will be in charge till Miss Morton's return.

The Kingston Chapter of the Graduate Nurses' Association of Ontario met on Tuesday, February 1, 1916, in the Nurses' Residence.

The President, Miss C. Milton, was in the chair. It was decided to join the General Hospital Alumnae Association and hold a food sale on February 26th. A nice sum was realized from the sale and will be used for Red Cross work.

The association has just packed two boxes of operating-room towels, sheets and pneumonia jackets and sent them with the Queen's reinforcements, who left on February 28th for Cairo, Egypt. All of the graduate nurses in Kingston are still busy sewing every Wednesday for the Red Cross.

Mrs. George Nicol, President of the Kingston General Hospital Alumnae Association, is spending two months in Florida.

Mrs. W. J. Crothers, Jr., Vice-President of the association, spent three weeks in Atlantic City and New York last month.

Miss Annie Hiscock, of Kingston, is on private duty at Saranac Lake, Adirondacks.

Miss Evelyn Patterson, of Kingston General Hospital, was on special duty in Wellesley Hospital, Toronto. On her way home she made a visit in Hamilton with Mrs. Gilmore (M. Stafford, '03, K.G.H.), and Miss Walsh, '04, K.G.H., at Cobourg Hospital.

Miss Marion Armstrong, of Kingston, and Miss Anita Carscallen, of Centerville, K.G.H. graduates, are going to England with the Ontario Hospital Unit.

Five of Kingston General Hospital graduates—Misses Helena Hinch, Lillian Connerty, E. G. Moore, Pearl Morton and Ethel MacNamee—left on February 28th with Queen's reinforcements for Cairo, Egypt.

Miss E. C. Mercer, of Kingston, K.G.H. '12, who went over with the First Canadian Contingent, and who has been on military duty in France for one year, and in the Duchess of Connaught Hospital, England, for two months, has sailed for her home in Kingston to spend a few weeks.

The death occurred in Kingston General Hospital, on February 23rd, of Mrs. John D. Shibley, of Harrowsmith. The deceased was formerly Miss Jessie Winter, who graduated in 1906 from the K.G.H. Training School for Nurses. Mrs. Shibley was a life member of the alumnae association and always took a keen interest in the work.

Another sad death occurred in the Kingston General Hospital of Miss Grace E. Nourse, of Sherbrooke, Que. Miss Nourse was on military duty with Queen's Hospital reinforcements, who left Kingston on February 28th for Cairo, Egypt. Miss Nourse was a graduate of K.G.H., '04.

Miss Agnes B. Munnoch and Miss Marion Soutar, graduates of Victoria Hospital, London, have received appointments to the Queen Alexandra Imperial Military Nursing Service and are awaiting the call to go overseas.

Miss Margaret McIntosh, Superintendent of the operating room of Victoria Hospital; Miss Ina F. Pringle and Miss Maud Hanna, all graduates of Victoria Hospital, have joined the staff of the Ontario Government Hospital. Miss McIntosh is a graduate of the Post-Graduate Hospital of New York.

Quebec

The usual monthly meeting of the Montreal Woman's Hospital Alumnae Association was held in the Nurses' Home on Tuesday,

January 18th. Mrs. Chisholm took the chair. Miss Trench proposed that the nurses work at the meetings for the Edith Cavell Chapter of the Daughters of the Empire.

Mrs. Chisholm resigned her office as president, having accepted a position to take charge of a hospital at Dragon, near Rigault, Que. Miss Francis takes her place.

Presentations of electric flashlights were made to Mrs. Chisholm, Mrs. Shaw and Miss Bryant. The latter two expect to be called any time now for overseas.

Miss Rose left for overseas in January.

Col. Spear, M.D., gave some very interesting descriptions of his sojourn at Cliveden, England. He explained how splendidly the soldier patients were cared for during their well-earned furlough and described some of the splendid recreations afforded by this most beautiful estate to patients and hospital staff alike.

The regular monthly meeting of the Western Hospital Alumnae Association, Montreal, was held in the board room on Monday, February 14th. After the usual routine business Dr. C. Guid gave a very interesting talk on Twilight Sleep.

Miss Edith Gallagher, class '14, has left for overseas service with No. 6 General Hospital.

The sudden passing of Miss Grace E. Nourse, Nursing Sister of Stationary Hospital No. 5, Queen's University, Kingston, has left a great gap in the nursing ranks of Sherbrooke, Que. One who was privileged to call Miss Nourse friend says of her: "Our profession in Sherbrooke will feel the loss of Miss Nourse keenly for many years to come. She was of the finest type of nurse, who had consistently upheld the noble ideals of her profession through all her years of service. Her influence for good, among the younger nurses particularly, was very strong, and it is largely to her interest and enthusiasm we owe our nurse's association. It was only after much thought and from a stern sense of duty that she volunteered for the service which cost her her life. She well appreciated the danger and sacrifice involved, but when the opportunity came to her she felt it was her call to "do her bit" for the Empire.

Her memory will ever be a stimulus to higher standards and better work to her sister nurses and friends. She was laid to rest in her service uniform with full military honors. The service was most impressive. The Rev. G. Ellery Read spoke as follows:

We are gathered here to pay our tribute of love and honor to the memory of one who lived her life and won from those whom she served that which cannot be expressed in words howsoever eloquent they might be. To those who knew her in intimate relations of home and friendship, those who were the recipients of her gracious and efficient

ministry in the sick room, or were her companions and fellow laborers, in the noble profession to which she had dedicated her life, anything I can say may seem superfluous or inadequate; because her life was spoken in living words. It is impossible to convey to those who did not know her life the noble idealism, the lofty sense of duty, the completeness of her devotion to the "daily round and common task," and yet it is altogether fitting that something be said, howsoever stammering and imperfect, to inspire us all to a higher and holier devotion to those claims that life makes upon us. The first characteristics that impressed itself upon those who knew her best was her poise, not using the word merely in the sense of self-control or self-possession, but because she had seen and understood life's truest purpose and had responded to its noblest claims. She had weighed the interests of life as they are commonly known to us and given herself to all that makes life worth of our striving and attainment, and she accomplished this because of her undivided devotion to these ideals. She was what we call in the true sense of the word, whole-hearted, and her whole-heartedness was inspired by religious idealism. I do not use the word "religious" in the sense of something that takes us out of the world, but rather that which changes the whole character of life and makes the commonplace holy and divine. It was not enough for her to do simply what had to be done. She sought to know what others had to do and to what extent she could help them, and it was because of this constantly extending range of sympathies that she dedicated her life to the work of the Red Cross. She had undertaken this because she believed that in this hour of our Empire's great need, when our men are giving their lives for the sake of the emancipation of humanity from the tyranny and despotism of militarism she should take her part in gracious healing. Perhaps from the time that Florence Nightingale fared forth to the Crimea and dedicated her life to the great mission she accomplished, it would be impossible to find one who with truer and nobler conception of her work entered into it with all the joy of her heart. To-day we are face to face with this inexplicable mystery, her purpose unaccomplished, her life here ended. I am not here to offer any explanation, but simply to plead for faith that in the ultimate summing up she who has gone from us with her work apparently unaccomplished may yet have done more than we are able to understand. Emerson has said: "It is the fine souls that serve us." In her there dwelt a fine soul, and in the Providence of God, she served while she was here, and therein God's purposes are not defeated.

In closing, Mr. Read read the following quotation from Bishop Brooks: "Do not dare to be so absorbed in your own life, so wrapped up in listening to the sound of your own hurrying wheels, that all this vast pathetic music, made up of the mingled joy and sorrow of your

fellow men shall not find your heart and claim it and make you rejoice to give yourself for them. Be sure that ambition and charity shall grow mean unless they are inspired and exalted by religion. Energy, faith, love—these make the perfect man."

NOVA SCOTIA

Miss Bertha Pickels, of Nicteaux Fall, Nova Scotia, graduate of the New England Hospital, Boston, Mass., has recently been appointed Assistant Superintendent of Nurses at Victoria General Hospital, Halifax.

Miss Pickels is thoroughly equipped for her work, having held several executive positions both in Massachusetts and New York, and was for two and a half years Assistant Superintendent of Nurses at Grace Hospital, Toronto.

MARRIAGES

On January 11, 1916, at Toronto, Miss Ella Beatrice Farr, graduate of Victoria Memorial Hospital, Toronto, to Rev. T. F. Summerhays, priest in charge of the Church of the Good Shepherd, Mount Dennis, Ontario.

At Orillia, Ont., on June 30, 1915, Miss Jean Strathearn, graduate of Orillia General Hospital, class '14, to Mr. Horace Holmes, Orillia.

At Orillia, on January 1, 1916, Miss Katie Whiting, graduate of Orillia General Hospital, class '13, to Mr. Thos. McDonald, Orillia.

At Snelgrove, Ont., on January 18, 1916, Miss Elsie Lowe, graduate Orillia General Hospital, class '12, to Mr. Harold Walker, Coldwater, Ont.

DEATHS

At Toronto General Hospital, on February 26, 1916, Nursing Sister Elsie G. Ross, graduate of Toronto General Hospital, who had been on military duty at Exhibition Camp Hospital since its establishment.

THE NURSES' LIBRARY.

Surgical and Gynaecological Nursing—By Edward Mason Parker, M.D., F.A.C.S., Surgeon to Providence Hospital, Washington, D.C., and Scott Dudley Breckinridge, M.D., F.A.C.S., Gynaecologist to Providence Hospital, Washington, D.C.

Octavo, 425 pages, 134 illustrations, cloth $2.50. J. B. Lippincott Company, 201 Unity Building, Montreal.

This text book is written to meet the needs of the surgical nurse and is most complete. It is divided into six parts, each containing several chapters. The subjects dealt with in the different parts are: Infection, The Field of Surgery; Minor Technic in Surgical Nursing, The Patient, The Operation, Supplementary Chapters.

A Text Book of Physics and Chemistry for Nurses—By A. R. Bliss, Jr., Ph.G., Ph.Ch., A.M., Phm.D., M.D., Lecturer on Materia Medica and Chemistry, Grady Hospital Training School for Nurses, Atlanta; Professor of Pharmacology, Emory University School of Medicine; formerly Professor of Chemistry and Pharmacology, Birmingham Medical College, and Graduate School of Medicine, University of Alabama, and A. H. Olive, A.B., A.M., Ph.Ch., Phm.D., Lecturer on Chemistry, Hillman Hospital Training School for Nurses, Birmingham; Professor of Physics and Chemistry, Howard College; formerly Associate Professor of Chemistry, Birmingham Medical College, and Graduate School of Medicine, University of Alabama.

Crown octavo, 225 pages, 49 illustrations, cloth $1.50. J. B. Lippincott Company, 201 Unity Building, Montreal.

The authors here furnish the student nurse in concise form a simple and clear presentation of those portions of the sciences—physics and chemistry—which are of special interest and importance.

First Aid in Emergencies—By Eldridge L. Eliason, A.B., M.D., Assistant Surgeon University of Pennsylvania Hospital, Assistant Surgeon to the Howard Hospital; Assistant Surgeon to the Philadelphia General Hospital; Assistant Surgeon American Stomach Hospital, former Lecturer on "First Aid and Emergencies" in the University of Pennsylvania Medical School, etc.

Crown octavo, 204 pages, well illustrated, cloth $1.50.

J. B. Lippincott Company, 201 Unity Building, Montreal.

This book is intended for the laity, all who should have some knowledge of first aid—firemen, police, sailors, boy scouts, factory workers, etc. The facts are presented clearly and simply so that all may understand.

Question Manual—Compiled by May Kennedy, R.N., Chief Nurse, Kankakee State Hospital, Kankakee, Illinois; formerly Chief Nurse, Anna State Hospital, Anna, Illinois; formerly member of Nurses' Examining Board of the Illinois State Civil Service Commission.

Crown octavo, 158 pages, cloth $1.00. Whitcomb and Barrows, Boston, Mass.

The object of this manual is to assist nurses in review work. "The questions are those that have been used in examination for State Registration and for Civil Service positions."

Public Health in Springfield, Illinois," by Franz Schneider, Jr., a report which, besides giving a careful analysis of the Springfield situation, contains up-to-date and readable discussions of the various public health problems that confront American communities. Those engaged in public health administration or teaching, and sanitary engineers, will find in it much of special professional interest. Social workers and the laity may gain from it a clearer understanding of what the new public health can and should do, while municipal authorities will find it helpful in deciding the difficult question of what funds the health department should be allowed and what reasonably may be expected of it. To those contemplating a public health survey this report may be recommended as typical.

The report is 159 pages in length, is indexed, and is illustrated with 14 maps, 38 charts and 27 photographs. The chapter headings are as follows:

Life Wastage in Springfield; Fundamental Facts Regarding Springfield; Infant Mortality; Contagious Diseases of Children; The Springfield Tuberculosis Situation, by Dixon Van Blarcom; Extent of Tuberculosis in Springfield; Existing Agencies for the Control of the Disease; Suggestions for an Adequate Campaign; Where the Responsibility Lies; Typhoid Fever; The Venereal Diseases; City Water Supply; Sewerage and Sewage Disposal; Wells and Privies; Milk Supply; Food Supply; Other Sanitary Conditions; Springfield's Public Health Service; Summary and Conclusions; Appendices.

Published by Department of Surveys and Exhibits, Russell Sage Foundation, 130 East 22nd Street, New York. Price 25 cents.

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Regular Meeting—First Monday, 4 p.m.

PUBLISHERS' DEPARTMENT

FEET AND BOOTS

By V. E. Taplin

In December and January issues, under similar headings, an effort has been made to convince you that wearing a foot-deforming shoe is a crime, first against yourself, second against your friend, and third against your employer. A lady in Saskatchewan wrote that in her opinion no person has a right to intentionally make themselves ugly, and that there is nothing about our person so disgusting as intentional foot deformity. We do not covet pug noses, small heads, small eyes, or small statures, all of these should be normally developed, but when it comes to the feet, abnormalities are apt to be admired by the thoughtless masses. A wave of sentiment in favor of drastic changes in footwear is apparent and it is safe to prophesy that within a few years it will be as much out of order to wear high heels and pointed-toed millinery on the street and at business, as it would be to wear your opera gown when selling wall paper or carpets. There is a place for everything and everything should be in its place. Certainly high heels and narrow toes have no place in business and when walking, not more than a heavy walking boot has in a drawing room.

Manufacturers, designers, and wearers of shoes appear to vie with each other in producing and have produced some of the most amazing shapes, which the human foot is afterward forced to assume. The foot of the child is plastic, so much so, in fact, that they can be bound and moulded into a hopeless condition, in which the natural machinery of the foot is so much disturbed that even reasonable efficiency is not to be expected.

The museum for "Safety First," of New York, estimates that 90 p.c. of industrial workers have foot trouble, which decreases their earning capacity by from 10 p.c. to 50 p.c. It is probably one of the greatest economic questions of the day, and yet there is only a small handful of people who as yet realize that a foot should not give trouble more than a hand, or that a hand, or other parts of the body would cause equal discomfort if equally abused.

Imagine for a moment that fashion would decree that it was inelegant for our fingers to spread, and would produce a leather case with the object of gradually shaping them into a narrowed position—would we wear them? At first thought you would say "no," and mean it, but after all would it not really depend on what "Mrs. Jones" did?

Next month I hope to explain the proper use of the foot and why it is possible for Mary to walk gracefully and easily down the street, while Jennie just pegs along with a stiff rheumatic halt, and the effect each has on the muscles of the foot.

In the meantime just toe straight ahead.